Exposing Diverse Students to Oral Health Professions

Career Exploration

New Jersey Department of Health and Senior Services

Connecting Diverse Communities

NEW JERSEY DEPARTMENT of HEALTH and SENIOR SERVICES

State of New Jersey
DEPARTMENT OF HEALTH AND SENIOR SERVICES
PO BOX 360
TRENTON, N.J. 08625-0360

JON S. CORZINE
Governor

www.nj.gov/health

Heather Howard
Commissioner

Dear Student Advocate,

The Office of Minority and Multicultural Health is pleased to provide Career Exploration: Exposing Diverse Students to Oral Health Professions, a tool kit designed to help anyone who works with students to encourage them to pursue careers in oral health. With this tool kit, we hope to specifically inspire underrepresented minority students who may not have role models in dentistry who resemble themselves to realize that they too can become dentists, dental hygienists or dental assistants.

New Jersey's racial and ethnic minority populations are growing, and so too is the state's need for a diverse health professional workforce. Minority doctors, dentists, nurses and public health workers can play a vital role in improving the health of minority communities. Recent data shows that dentists from underrepresented racial and ethnic groups are more likely than White dentists to treat minority populations. In 2000, Black dentists reported that 61.8 percent of their patients were Black; 45.5 percent of Hispanic dentists' patients were Hispanic; and 76.6 percent of White dentists' patients were White. Studies have also shown that more patients participate in their own health care when seeing a provider of the same race which can greatly impact a patient's health.

One aim of the OMMH is to develop initiatives to increase the number of minorities in health professions. With collaboration from the New Jersey Dental Association, the purpose of this tool kit resource is to attract qualified high school students into learning more about careers in the oral health profession. This tool kit contains information that will help you arrange to have an oral health professional visit your school, provide facts about oral health careers, and outline various resources you can discuss with your students and their parents to get them on the path to dentistry.

Increasing the number of minority oral health professionals is critical to improving health care delivery throughout the system, and to addressing persistent racial and ethnic health care disparities. We appreciate your continued effort to facilitate programs and activities that empower students to achieve their career goals.

Sincerely,

Linda J. Holmes
Executive Director
Office of Minority and Multicultural Health

New Jersey Dental Association

www.njda.org

Dear Guidance Counselor:

What an exciting job you have. Every day you help young people uncover future possibilities at a time when they are as open as they will ever be. We are hopeful that while guiding these students in choosing a career path, you would consider the high-growth group of careers in the field of dentistry.

Dentistry offers many opportunities to fulfill one's career goals. Whether those goals include improving healthcare in the community, healing and educating people, conducting world-changing research, or experiencing lifelong growth opportunities, the field of dentistry has something for all who endeavor to pursue in this profession.

Careers as a dentist, dental hygienist, dental assistant or a dental lab technician are available to students of all backgrounds and education levels. In fact, many areas of dentistry are experiencing a shortage of professionals so the sky is the limit for the student who has the will and determination to excel. Some dental careers could have students earning above average wages in as little as nine months.

This tool kit, created by the New Jersey Office of Minority and Multicultural Health (OMMH) within the Department of Health & Senior Services, serves as a valuable resource for you. In it you will find, among other things, detailed descriptions of the various careers in dentistry, a list of accredited schools in New Jersey and seasoned dental professionals from a variety of cultural backgrounds who are willing to come to your school and speak with students about careers in dentistry or speak with them one-on-one in a more private setting.

We, at the New Jersey Dental Association, worked alongside the OMMH to create this informative tool kit for you and your students. Please do not forget to offer any of the dental professions to your students who are undecided about a career, especially those who have aptitudes in the sciences and like working with people. The opportunities in the dental profession are as available as they have ever been and we are here to help you guide students every step of the way.

Sincerely,

Steve Fink

Steven R. Fink, DMD
President

One Dental Plaza, P.O. Box 6020, North Brunswick, NJ 08902-6020 (732) 821-9400

Professions

Average Salary: $28, 496

Years in School: 0-2, after high school graduation

Job outlook: Excellent

Dental Laboratory Technician

A dental lab technician (also called a dental technician) produces the restorative or corrective devices-(e.g., a retainer)-that are ordered by dentists for their patients.

Dental lab technology is ever-expanding, as technology continues to advance rapidly. Technicians use a variety of high-tech materials, such as ceramics, plastics and metals to create functional and realistic tooth replacements and other restorative devices. They also must have a keen understanding of the mechanics of both the mouth and dental devices

Ideal Candidates:
The ideal candidate possesses excellent hand-eye coordination, good color perception, dexterity with small instruments and an interest in materials science.

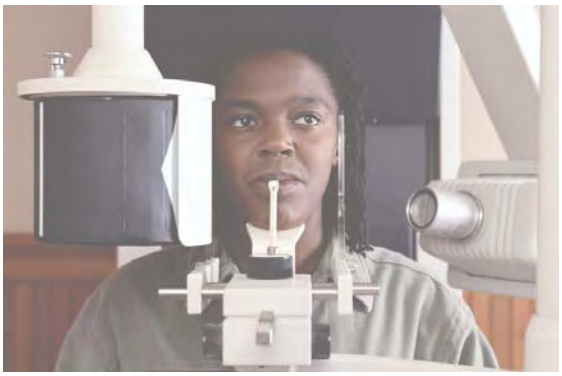
Work Conditions:
Most dental technicians are employed in commercial dental laboratories, which can be small or large. The military employs a number of dental technicians. Highly experienced technicians may become teachers in a dental technology program. The work is extremely meticulous and time consuming. Salaried technicians usually work 40 hours/week, but the opportunity to become self-employed is great.

Academic Requirements:
Most Dental laboratory technicians learn their craft on the job. Training in dental technology is also available through community colleges, vocational-technical institutes, and the Armed Forces. Training programs vary but a fully trained dental technician spends up to 4 years in training.

After training, dental lab technicians may become certified by taking and passing the **Certified Dental Technician** exam offered by the National Association of Dental Laboratories.

Accredited Dental Lab Technician schools in New Jersey: http://shrp.umdnj.edu/programs/health_careers/programs/

For more information on becoming a dental lab tech, see the **National Association of Dental Laboratories (NADL)**.
http://www.nadl.org/careers.cfm



Average Salary: $27, 248

Years in School: 1-2, after high school graduation

Job outlook: Excellent

Dental Assistant

Dental assistants perform a variety of patient care, office, and laboratory duties. They often schedule and confirm appointments, receive patients, keep treatment records, send bills, receive payments, obtain dental records, and order supplies and materials. They also sterilize instruments and equipment, prepare tray setups for dental procedures, and instruct patients on oral health care.

Dental assistants also work alongside the dentist as s/he examines and treats patients. Additional duties differ from state to state, based on the Dental Practice Act. Under the dentist's direction, some assistants prepare materials for making impressions and restorations, expose radiographs and process dental x-ray film.

Work Conditions:
Dental assistants can be found in private dental practices, dental school clinics, and hospitals. Their work area is near the dental chair so they can arrange instruments, materials, and medication and hand them to the dentist when needed. Dental assistants have a 35-40 hour work week, which may include weekends. In New Jersey, an assistant must be supervised by a dentist.

Academic Requirements:
Dental assistants are trained in an accredited dental assistant program offered by colleges, community colleges and vocational-technical institutes or the Armed Forces. Programs can range from 8-18 months and upon completion of the program you must take the Certified Dental Assistant exam offered by the Dental Assisting National Board (http:// www.danb.org/).

Average Salary: $55,307

Years in School: 2, after graduating with an Associate's or Bachelor's degree

Job outlook: Excellent

Dental Hygienist

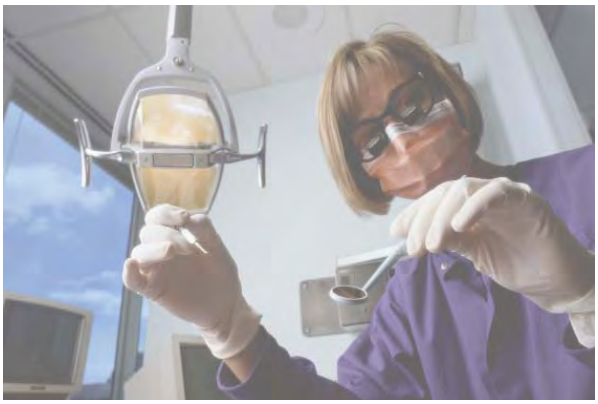
Dental hygienists are preventive oral health professionals who have graduated from an accredited dental hygiene program. They are licensed in dental hygiene to provide educational, clinical, research, administrative and therapeutic services.

The dental hygienist educates patients on effective oral hygiene; assesses patients' overall health in order to determine the presence or absence of disease; develops a dental hygiene diagnosis based on clinical findings; and performs the clinical procedures outlined in the patient's treatment care plan.

Clinical procedures performed typically include removal of plaque, tartar and stains from the teeth, exposing and processing dental x-rays, applying cavity-preventive agents such as fluorides and sealants, and administering antimicrobial agents. In addition, they also prepare clinical and laboratory diagnostic tests for interpretation by other health professionals.

Working Conditions:
Dental hygienist provides clinical services in a variety of settings such as private dental practices, community health settings, hospitals, prisons, schools and state and federal government facilities. Dental hygienists work closely with dentists and provide care and education that is vital to a patients' oral health. In addition to clinical practice, there are career opportunities in education, research and public health. Flexible work schedules can be a highlight of this profession.

Academic Requirements:
Dental hygienist must graduate from an accredited dental hygienist program based in an institution of higher education. Hygienists must also be licensed in the state in which they practice. Requirements for licensure vary from state to state, but generally include successful completion of an accredited entry-level program, successful completion of the National Dental Hygiene Board examination, a state or regional clinical examination, and a law and ethics examination.



Those interested must obtain at least an associate's degree prior to entering a dental hygiene program. Programs are at least two years.

Average Salary: $120,000

Years in School: 4, after graduating from a four-year university.

Job outlook: Excellent

Dentist

Dentistry is the branch of science devoted to maintaining oral health. Dentists are licensed health professionals who provide a wide range of oral health care that contributes to their patients' overall health. In addition to general dentistry, there are nine specialized areas of dentistry that include:

Endodontics- diagnoses and treatment of injuries specific to the dental nerve and pulp
Oral and Maxillofacial Surgery- treatment of injuries, diseases, and defects of the neck, head, jaw and associated structures

Oral and Maxillofacial Pathology- study and research of causes, processes and effects of diseases with oral manifestations

Oral and Maxillofacial Radiology- taking and interpretation of conventional, digital, CT, and imaging modalities of oral-facial structures and diseases

Orthodontics- diagnosis and treatment of problems related to irregular dental development, missing teeth and other abnormalities

Pedodontics- treatment of children from birth to adolescence
Periodontics- treatment of and corrective surgery on tissue and supporting bones to treat gum disease

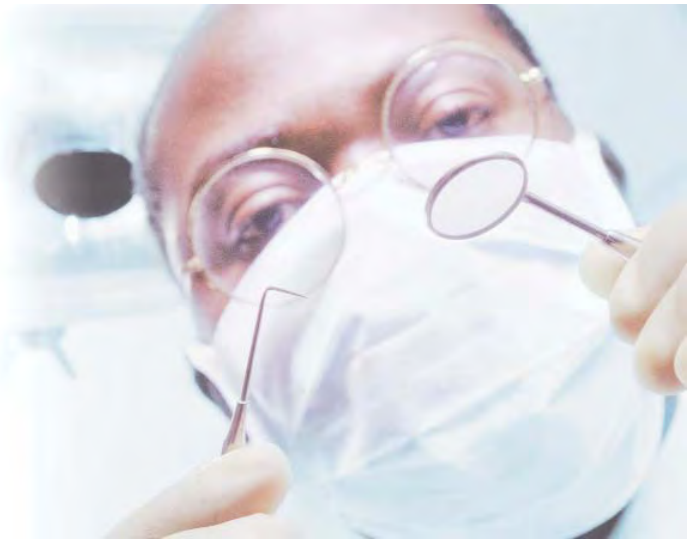
Prosthodontics- restoration and replacement of teeth damaged by decay or lost from trauma or disease with fixed or removable appliances constructed with dental materials

Public Health Dentistry- maintenance of oral health in a community-based setting

Working Conditions:
Approximately 90% of all dentists are engaged in the delivery of care through private practices. However some work in dental schools, hospitals or in the Armed Forces. Full-time dentists spend about 35 hours per week in their practice. They have great flexibility in determining how many hours they choose to work in a week.

Academic Requirements:
To practice dentistry you must graduate from an accredited dental school. There are 56 accredited dental schools in the U.S. The length of training beyond high school is 8 years, including a bachelor's degree and four years of dental school.

In order to be accepted into dental school, you have to take the American Dental Association's Dental Admissions Test examination. After graduating dental school and passing your licensure examination, you can begin practicing dentistry. Though, certain states may require additional testing in order to practice in the state.



Bring An Oral Health Professional to your School

Bring An Oral Health Professional to Your School!

This will act as a step-by-step guide for you to host a program geared towards exposing high school students to oral health professions. Your goal is to be prepared to give children from underrepresented minority groups a better idea of what oral health professionals do and to help them recognize that they, too, can be successful members in the profession.

1. Arrange a date and time with the principal. Remember that February is Oral Health Month!

2. Contact the New Jersey Dental Association to arrange for an oral health professional to visit your school.

Eric R. Elmore
Director of Marketing & Communications
New Jersey Dental Association
P: (732) 821-9400
P: (732) 821-1082
E: eelmore@njda.org
I: www.njda.org

3. Send a confirmation letter to the guest speaker.

4. At least one week prior to the visit, post information about the event in the school and encourage parents to attend.

5. One week prior to the visit, confirm visit with the oral health professional. Make sure directions are given to the guest speaker and arrangements are made for presentation materials.

[Sender]

[Type the sender company address]

[Type the recipient name]

[Type the recipient address]

[Type the salutation]

As an oral health professional who applies their education every day, you recognize that every child has the potential to achieve. Showing young people the different paths available to them is an important part of helping them achieve that potential.

Through *Career Exploration: Exposing Diverse High School Students to Oral Health Professions*, I would like to introduce our students to the field of dentistry. This program will allow oral health professionals an opportunity to visit our school to encourage young people, especially those in underrepresented minority groups, to pursue dental careers.

Minority populations in America are growing faster than any other population group. However, this growth has not been witnessed in the number of health professionals in this country, including dental and medical students and faculty.

We believe that young students from underrepresented groups need to meet-not just hear about -real life African American, Hispanic and Native American dental professionals who can share stories about their own experiences and perhaps inspire these students to follow the same path. Your participation in the Career Exploration program will help us meet that objective.

I sincerely appreciate your participation in this important event for our students on [insert date and time]. I look forward to working with you and please feel free to contact me with any questions.

Sincerely,

[Type the sender name]

[Type the sender title]

Closing the gap: Oral health facts

Increasing Student Diversity to Close Oral Health Gap

Recent data shows that dentists from underrepresented racial and ethnic minorities are more likely to treat minority populations than non-minority dentists. In 2000, black dentists reported that 61.8 percent of their patients were black; 45.4 percent of Hispanic dentists' patients were Hispanic; and 76.6 percent of White dentists' patients were White.[1]

Dentists & patients by race/ethnicity

%Patients:	White	Hispanic	Black	Asian
Dentists				
White	76.6%	8.5%	10.5%	3.2%
Hispanic	43.6%	45.4%	9.8%	3.0%
Black	27.0%	7.9%	61.8%	2.3%
Asian	47.5%	14.5%	11.5%	25.1%

(ADA 2000)

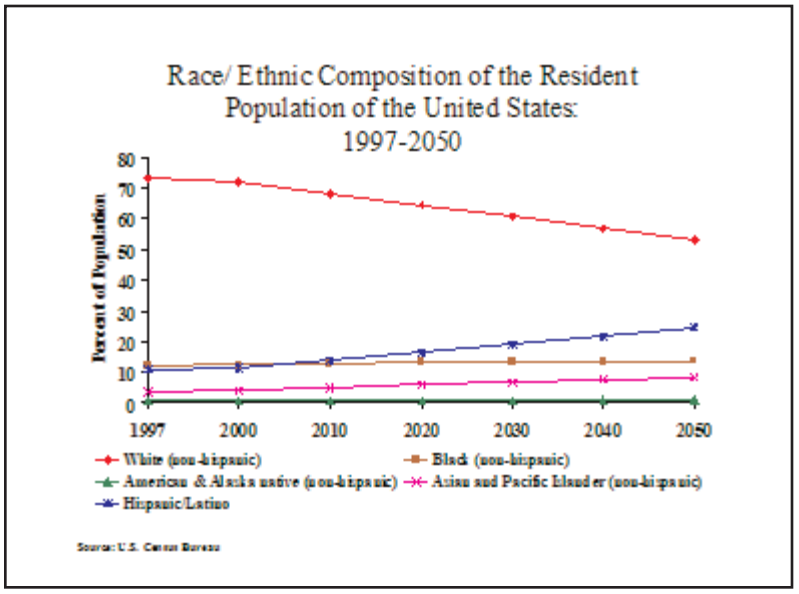
ADEA

The racial and ethnic composition of the workforce must change if there are to be enough dentists to meet the oral health care needs of a diverse patient population. The American Dental Education Association estimates that by 2020, there will be 54.2 dentists for every 100,000 people, the lowest since World War I, and there may be a substantial shortage of dentists as early as 2010.

The falling ratios are attributable to several factors: the number of dental school applicants declined by approximately 8-10 percent since 1997, and dental schools reduced their enrollment by about 30% in the 1980s from about 5,200 to the current 4,300 graduates per year.

Strategic measures are needed to increase the number of underrepresented minority graduates. In 2004-05, 6 percent of enrolled dental school students were Black; 6 percent were Hispanic, and .6 percent were American Indian.

And while minority dental school enrollments are falling, the minority populations are growing. Demographers project that by 2050, 58 percent of the population will derive from racial and ethnic minority groups.



1. Financing A Dental Education: Implications for URMs and the W.K. Kellogg/ADEA Access to Dental Careers (ADC) Grant. Chicago: American Dental Association, 2001. From a paper delivered at the 43rd Annual Deans' Conference in Scottsdale, Arizona, Nov. 13, 2001.

Pipeline, Profession & Practice: Community-Based Dental Education is a national program supported by the Robert Wood Johnson Foundation in collaboration with The California Endowment, and the W.K. Kellogg Foundation.

Source: http://www.dentalpipeline.org/elements/URM/increasingstu.html

COMMENTARIES

Addressing Health Care Disparities and Increasing Workforce Diversity: The Next Step for the Dental, Medical, and Public Health Professions

The racial/ethnic composition of our nation is projected to change drastically in the coming decades. It is therefore important that the health professions improve their efforts to provide culturally competent care to all patients.

We reviewed literature concerning health care disparities and workforce diversity issues—particularly within the oral health field—and provide a synthesis of recommendations to address these issues.

This review is highly relevant to both the medical and public health professions, because they are facing similar disparity and workforce issues. In addition, the recent establishment of relationships between oral health and certain systemic health conditions will elevate oral health promotion and disease prevention as important points of intervention in the quest to improve our nation's public health. (*Am J Public Health*. 2006;96:2093–2097. doi:10.2105/AJPH.2005.082818)

Dennis A. Mitchell, DDS, MPH, and Shana L. Lassiter, MA

THE AMERICAN DENTAL Education Association (ADEA) recently released a position paper that addressed academic dental institutions' (ADIs') roles and responsibilities for improving the oral health of all Americans.[1] The projected changes in our nation's demographic composition[2] and the underrepresentation of several minority groups within the oral health care workforce indicate that oral health professionals will be ill prepared to provide quality culturally competent care to many of their patients.[1,3] Therefore, this is the opportune time for both dental and nondental oral health stakeholders (including physicians and public health professionals) to review and augment their efforts for actively implementing strategies that will achieve a culturally competent workforce devoted to providing quality oral health care to all patients. The association between oral health and systemic health[4] shows that collaborations among oral health professionals, medical professionals, and public health professionals will be necessary for adequately addressing both the oral health and the general health of our nation.

We reviewed relevant access to care and workforce diversity literature, and we will provide a synthesis of recommendations offered in the ADEA's position paper and those put forth in recent reports by the Sullivan Commission,[5] the Institute of Medicine,[6,7] the Office of the Surgeon General,[4] and the American Dental Association.[3] In keeping with the ADEA's position piece, we emphasize the role of academic institutions (particularly ADIs), which are the educators and the nurturers of our future health professionals.[1]

HEALTH DISPARITIES IN THE UNITED STATES

The Haves and Have Nots

With the release of their position paper, the ADEA has placed the issue of disparate access to quality oral health care at the feet of current and future oral health professionals of all races and ethnicities. It has been documented that impoverished and racial/ethnic minority populations receive substandard health care compared with their more affluent White counterparts.[4,7] In 2001, there were more than 31.4 million individuals who lived in 1480 health professional shortage areas, nearly double the 780 shortage areas identified in 1990. Racial/ethnic minorities are the majority of individuals who reside in health professional shortage areas; therefore, they bear much of the emotional, financial, and physical burden of poor oral health.[4,7]

Compounding this issue is minority overrepresentation in lower socioeconomic groups. As highlighted in the ADEA's position paper, health care services in the United States are inappropriately treated as marketplace commodities, i.e., those who are unable to pay have less access to quality resources.[1,3,5] Consequently, economically disadvantaged minority patients bear the brunt of poor oral health, receive lower-quality health care, and are less likely to receive routine care compared to more affluent White patients.[4,7]

Increasing Workforce Diversity

The absence of a sound patient–provider relationship is one factor that contributes to disparities in the quality of care received by minority populations, which returns us to the issue of health care workforce diversity. Several publications have shown the importance of a racially diverse workforce for improving underserved populations' access to care. According to the Sullivan Commission's report, Black patients are significantly more likely to receive their care from Black dentists (who treat almost 62% of Black patients) than from White dentists (who treat 10.5% of these patients).[5] Similarly, surveys of dentists' practice trends have shown that dentists who are themselves underrepresented minorities treat significantly higher proportions of urban, less

TABLE 1—Race/Ethnicity Distribution Within the US Population (Current and Projected) and Among the Health Professions

	US Population, %		Health Professions, %		
	Current (2000 Census)	Projected (Year 2050)	Medicine	Dentistry	Nursing
White, non-Hispanic	69.4	50.1	51.0	86.0	86.6
Asian/Native Hawaiian/Pacific Islander	3.7	8.2[a]	8.6	7.0	3.7
Black	12.3	14.6	2.4	3.4	4.9
Hispanic	12.5	24.4	3.3	3.3	2.0
Native American/Alaskan Native	0.9	1.8[a]	0.05	0.1	0.5
Non URM totals	73.1	58.3	59.6	93.0	90.3
URM totals	25.7	40.8	5.8	6.8	7.4

Sources. US Census Bureau[2,12]; Sullivan Commission, 2004[5]; Weaver et al., 2005.[13]
Note. URMs = underrepresented minorities. Non-URM and URM values do not total 100% because "other" and "unknown" categories were excluded.
[a]The US Census Bureau includes Native American/Alaskan Native and Native Hawaiian/Pacific Islander individuals in a broad "all other races" category; therefore, these values are estimates. Some groups included in the Asian/Native Hawaiian/Pacific Islander category are also considered URMs. Unfortunately, the available data do not allow the separation of these groups.

formally educated, and lower-income patients compared with their non–underrepresented minority peers.[8,9] Workforce diversity also has been associated with both greater satisfaction with care received and improved patient–provider communication.[6,7,10] Conversely, the lack of a diverse workforce may foster lingual and cultural barriers, bias, and clinical uncertainty within the patient–provider relationship.[7,11]

Despite the clear benefit of increasing workforce diversity, the racial/ethnic composition of the health professions workforce, including the dental workforce, fails miserably to reflect the increasing diversity of the US population. According to the 2000 Census, African Americans, Hispanics, and Native Americans/Alaskan Natives composed 12.3%, 12.5%, and 0.9% of the US population, respectively (one quarter of the US population).[12] However, within the health professions, these underrepresented minorities composed only 5% of dentists, 6% of physicians, and 9% of nurses in 2004 (Table 1).[5]

A LOOK TO THE FUTURE

A Diverse Workforce for Our Rapidly Changing Nation

Unfortunately, indicators of future diversity at the highest level (doctoral-level professionals) within the health care workforce are far from reassuring. In 2004, underrepresented minorities composed only 11.1% (dental),[13] 13.52% (medical),[14] and 7.36% (public health)[15] of doctoral-level graduates in the health professions (Table 2). These numbers show the dearth of underrepresented minorities in positions of leadership within the health care workforce and the critical need for additional efforts to strengthen the pipeline of qualified underrepresented minority students.

Future trends in the provision of care to underserved populations also are disquieting. It has been shown that underrepresented minority health professionals are more likely than their non–underrepresented minority counterparts to serve in areas of need.[5] Similarly, the ADEA's survey of graduating seniors in the class of 2004[13] indicates that underrepresented minority oral health professionals are likely to continue as the primary care providers in underserved communities unless there is an active intervention. Among the 2004 graduates, Blacks were significantly more likely to expect a patient load that includes a large percentage (>50%) of underserved patients.[13] Compared with White students, Black students tended to place a higher premium on "the opportunity to serve vulnerable and low-income populations" and to view low-income individuals as potential patients less negatively.[13] If steps are not taken to increase both workforce diversity and awareness of healthcare disparity issues,[7] projected changes within the US population—underrepresented minorities are expected to compose 40% of the US population by 2050[2]—will make the existing underrepresentations even more

TABLE 2—Race/Ethnicity Distribution Within the US Population (Current and Projected) and Among 2004 Health Professions Graduates

	US Population, %		2004 Health Professions Graduates, %		
	Current (2000 Census)	Projected (Year 2050)	Medicine	Dentistry	Public Health (Doctoral)
White, non-Hispanic	69.4	50.1	64.0	63.1	75.3
Asian/Native Hawaiian/Pacific Islander	3.7	8.2[a]	20.0	24.7	8.3
Black	12.3	14.6	6.5	4.5	4.7
Hispanic	12.5	24.4	6.4	6.3	2.4
Native American/Alaskan Native	0.9	1.8[a]	0.6	0.3	0.3
Non-URM totals	73.1	58.3	84.0	87.8	83.6
URM totals	25.7	40.8	13.5	11.1	7.4

Sources. US Census Bureau[2,12]; Sullivan Commission, 2004[5]; Weaver et al., 2005.[13]
Note. URMs = underrepresented minorities. Non-URM and URM values do not total 100% because "other" and "unknown" categories were excluded.
[a]The US Census Bureau includes Native American/Alaskan Native and Native Hawaiian/Pacific Islander individuals in a broad "all other races" category; therefore, these values are estimates. Some groups included in the Asian/Native Hawaiian/Pacific Islander category are also considered URMs. Unfortunately, the available data do not allow the separation of these groups.

glaring. Additionally, if the current resistance to service in underserved areas persists, patients who receive the least adequate care will continue to have the most difficulty identifying willing and competent providers. Under these conditions, it is easy to imagine the unacceptable persistence—and even worsening—of oral health disparities.

Light and Shadow by Jessica Keller. *Source.* http://www.serenityartistry.com.

Courtesy of Jessica Keller

The Role of Academic Institutions

The recruitment of additional underrepresented minority oral health professionals is one obvious approach to addressing the issue of oral health disparities.[4,5,7] Nevertheless, a comprehensive solution cannot be attained without the active participation and commitment of all dental professionals and oral health stakeholders. ADIs are an intuitive base for these efforts, because they are charged with the selection and the education of oral health professionals.[1,4] Several national organizations or committees, including the ADEA, have provided a plethora of recommendations for addressing workforce diversity and health care disparity issues. It is recognized that ADIs cannot exert direct influence in all areas where change is needed. Therefore, our review begins with those changes that institutions currently have the power and responsibility to implement and concludes with those actions that require continued advocacy and perseverence to effect change in external organizations and forces.

Making Diversity a Priority

First and foremost, ADIs must develop a culture conducive to change and the implementation of diversity initiatives.[5,6] This requires consistent support from the leadership within academic institutions,[5,6] including the formal declaration of each institution's commitment to diversity, cultural competency, and the elimination of oral health care disparities. This declaration can and should be made through a mission statement that clearly delineates the institution's goals and commitments with respect to diversity, community involvement, and the provision of culturally competent care.[5,6] Such a statement solidifies these responsibilities and values as necessary for the institution's success.

Furthermore, needs assessments within the institution and the community—and ongoing evaluations—are necessary to ensure that the appropriate diversity initiatives are adopted and smoothly incorporated into the fabric of each institution.[6] Recommended activities for helping institutions attain this goal include the creation of a mediation process for the investigation of perceived threats to the institution's commitment to diversity[6]; the appointment of a dedicated individual to oversee the development, implementation, and evaluation of diversity measures[5,6]; and the use of formal systems currently in place (e.g., yearly evaluations) to monitor and encourage active engagement in diversity-building initatives.[5,6]

Additionally, institutional support is needed for the implementation of curriculum and professional development changes aimed at improving diversity and cultural competency training. ADIs are urged (1) to incorporate diversity and cultural competency training into the predoctoral curriculum,[1,3,5–7] (2) to expose students to underserved populations early in their careers (e.g., through placements in community clinics),[1,4] (3) to provide ongoing cultural competency training to faculty and staff members,[5–7] and (4) to encourage interdisciplinary instruction that will advance the successful elimination of healthcare disparities by promoting collaboration among the health professions.[1,4,7]

Recruitment of Underrepresented Minority Students

The recruitment, retention, and support of underrepresented minority students is crucial to achieving a climate open to diversity.[1,3,5] Beyond the fact that underrepresented minorities are more likely to embrace care for the underserved as one of their career goals and responsibilities,[7,8,9,13] diversifying the student body will benefit the education of all dental students and the care of their future patients, regardless of race/ethnicity.[1,5,6] Improved underrepresented minority recruitment requires increased exposure to the health professions. Such exposure is particularly critical for the dental profession, which some fear and associate with other negative emotions.

Exposure to dentistry at several points along the educational path of underrepresented minority students is necessary for combating these associations. Efforts to reach students who may not have considered pursuing a

career in the health professions include (1) improving the identification and academic enrichment of potential underrepresented minority students at the K–12 and undergraduate stages of their education,[1,3–6,10] (2) developing campaigns that increase the visibility of health professions in communities where underrepresented minorities reside and thereby pique interest in pursuing health professions careers,[1,3] (3) recruiting underrepresented minorities who are taking nontraditional paths to careers in the health professions (including students who are enrolled in programs that bridge the 2-year and 4-year college experiences and individuals who seek a career change),[5] and (4) providing underrepresented minority students with psychosocial and skill-building services that will improve their chances for success in dental school.[1,5,6]

Enrollment and Support of Underrepresented Minority Students

As these initiatives work to increase the pool of underrepresented minority applicants, steps must be taken to ensure the enrollment of qualified underrepresented minorities in dental schools across the nation. Research has shown that underrepresented minorities tend not to perform as well as non–underrepresented minority applicants on assessments (standardized test scores and science course grades) on which admissions committees rely heavily.[5,6] Although these quantitative measures can provide useful, albeit limited and imprecise,[5,6] information about students' eventual performance, many have suggested reducing the heavy reliance on these measures in favor of a more thorough review of each applicant. Such a review would take into account qualitative aspects, such as life experience, previous experience navigating cross-cultural issues, multilingualism, and leadership potential.[5,6]

Should ADIs be successful in their attempts to increase underrepresented minority enrollment, they must not rest on the laurels of this success. Once enrolled, underrepresented minority students often face unique challenges[5,6]; therefore, academic institutions must assess the need for and provide appropriate academic (e.g., tutoring), psychosocial (e.g., counseling, mentoring), and financial (e.g., identifying aid sources, providing guidance on finance management issues) support services.[3–6]

Current underrepresented minority students are an important resource and should be encouraged to support their incoming colleagues. Regional collaboratives, such as those funded by the Dental Pipeline program,[16] are another valuable resource for underrepresented minority students. These collaboratives allow students to build support systems that include faculty members and students at nearby institutions. Such initiatives will ensure that underrepresented minority students fulfill their potential as oral health professionals, with the support they need and without undue burden.

The Role of Underrepresented Minority Faculty Members

Underrepresented minority faculty members can take leadership roles in the successful implementation of revised admissions procedures and initiatives aimed at supporting underrepresented minorities as they pursue a career in dentistry.[5,6] Institutions should, therefore, actively encourage and ensure the participation of underrepresented minority faculty members in decisionmaking committees, including admissions committees.[5,6] Because these faculty members are often overcommitted with mentorship and committee duties, such involvement should carry career-promoting incentives.[6] Additionally, increasing the pool of underrepresented minority faculty, including those with expertise in nondental fields such as education, will ease the load on the few underrepresented minorities currently in academia.[1,5,6] Increasing the number of underrepresented minority dental graduates is critical to increasing the underrepresented minority faculty pool, which further shows the need for ADIs to invest in their underrepresented minority students.

Collaboration with External Agencies

Increasing workforce diversity and access to care for the underserved are goals that require internal changes such as those described in the previous section, but opening academic institutions to collaboration with and influence by community-based stakeholders (e.g., community-based organizations that create and implement health promotion and disease prevention programs in economically disadvantaged neighborhoods) also is important. Academic institutions should actively engage their surrounding communities to remain aware of evolving oral health needs and to facilitate the dissemination of information about the institutions' diversity and cultural competency initiatives.[3,6] Additionally, community-based organizations can aid academic institutions with meeting those diversity and health care access goals by providing training in cultural competency and by being involved with the implementation of diversity initiatives whenever possible.[5,6]

Although there is much that ADIs can do to increase diversity and address disparity issues, there are areas where change is needed but cannot be achieved solely through institutional changes. For example, academic institutions should be involved in activities aimed at enriching the pipeline of potential underrepresented minority health professionals, but an overhaul of the public education system is needed to address disparities in the quality of education received by underrepresented minority children.[5,6] Academic institutions cannot initiate or control this overhaul process but they can advocate for changes to the educational system and provide technical assistance as needed (e.g., with science curriculum development).

The cost of a dental education also presents challenges that require support beyond the institution. The financial structure of ADIs is unique and contributes to the high cost of a dental education. Unlike other health profession schools, which are usually affiliated with hospitals or other external agencies, dental schools finance the didactic and clinical/externship portions of their students' educations. The additional costs incurred by dental schools are partially offset by tuition fees. These ever-increasing fees are a prohibitive burden for many underrepresented minority students and, therefore, are a barrier to the goal of increasing workforce diversity.[3,5,6] Because underrepresented minority students are likely to continue as leaders in the crusade to provide quality

care to the underserved, easing these students' financial burden can serve the additional purpose of improving access to care. Although many institutions offer internal sources of financial aid, innovative strategies for identifying additional financial resources are needed.[3,5,6] Funding from external sources is necessary for providing scholarships, tuition assistance, tax incentives, and loan repayment or forgiveness for oral health professionals who practice in underserved areas.[1,3–6]

Finally, although institutional self-regulation is important, accountability to outside organizations and stakeholders (e.g. communities) is crucial for ensuring sustained dedication to increasing diversity and eliminating disparities.[5,6] Institutions should cooperate fully with accountability measures and embrace them as an opportunity for evaluating progress toward meeting diversity, cultural competency, and care provision goals. Such cooperation is crucial for the implementation of several recommendations recently put forth, including external evaluations of data related to diversity initiatives (e.g., trends in underrepresented minority recruitment, enrollment, retention, and graduation) and the infusion of diversity goals into accreditation procedures.[5,6]

THE ROAD AHEAD

The ADEA's compelling statement to the dental education community should spur all oral health professionals to action. With the recommendations we discussed in mind, oral health professionals must work in concert with all interested stakeholders (including physicians and public health professionals) to develop and support initiatives that increase minority representation in the oral health care workforce and that reduce disparities in the quality of oral health care received by racial/ethnic minority and economically disadvantaged patients. Organized dentistry, and ADIs in particular, is the natural leader for these diversity-building and disparity-reducing efforts. But these institutions alone cannot provide effective solutions.

Recent research has shown the association between intraoral infections and multiple systemic conditions, including diabetes,[17,18] cardiovascular disease,[19] and adverse pregnancy outcomes.[20,21] If the association between oral health and systemic health is corroborated by the results of randomized multicenter clinical trials, oral health interventions will be recognized as important health promotion and disease prevention measures. The collaboration of dental and nondental oral health stakeholders (including all professional, philanthropic, community-based, and governmental organizations that have an investment in the public's health) is crucial for the success of any oral health intervention.[3,4] Collaboration among these multifaceted stakeholders will require the development of innovative strategies, but the benefits of improving the public's oral health will make this task worthwhile. Good systemic health cannot be achieved without attention to oral health.[4] Thus, oral health promotion and disease prevention could soon be the next frontier in the struggle to improve the overall health of our nation. ■

About the Authors

The authors are with the Office of Diversity and Multicultural Affairs, Columbia University College of Dental Medicine, New York, NY.

Requests for reprints should be sent Dennis A. Mitchell, DDS, MPH, Columbia University College of Dental Medicine, 630 W 168th Street, P&S Box 20, New York, NY 10032 (e-mail: DML48@columbia.edu).

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Contributors

Both authors originated and wrote the article.

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The Neglected Epidemic and the Surgeon General's Report: A Call to Action for Better Oral Health

The first US surgeon general's report on oral health will be released soon. Oral diseases have been called a "neglected epidemic,"[1–4] because, although they affect virtually the entire population, they have not been made a priority in our country. The surgeon general's report can help educate and sensitize policymakers and health leaders about the importance of oral health and the need to make oral health an integral component of all health programs. In the words of former Surgeon General C. Everett Koop, "You're not healthy without good oral health."

We must seize this unprecedented opportunity to ensure that the mouth becomes reconnected to the rest of the body in health policies and programs. It makes no sense that children, diabetic persons, or senior citizens with an abscess on their leg can receive care through their health insurance or a health program, but if the abscess is in their mouth, they may not be covered. For vulnerable populations and the "have-nots," the barriers to dental care are even greater.

Although we have made much progress in improving oral health since the 1970s as a result of fluoridation, fluorides, new technology, changing attitudes, and increased use of services, oral diseases are still a neglected epidemic. The facts speak for themselves. Seventy-eight percent of 17-year-olds have had tooth decay, with an average of 7 affected tooth surfaces (C. M. Vargas, unpublished estimates, Third National Health and Nutrition Examination Survey, 2000), and 98% of 40- to 44-year-olds have had tooth decay, with an average of 45 affected tooth surfaces (C. M. Vargas, unpublished estimates, Third National Health and Nutrition Examination Survey, 2000). Thirty percent of Americans older than 65 years have no teeth at all.[5] Twenty-two percent of 35- to 44-year-olds have destructive periodontal disease.[5] Finally, more Americans die from oral and pharyngeal cancer than cervical cancer or melanoma each year.[6]

Although tooth decay in children has decreased considerably,[7] it still affects most children and adults, especially as people live longer and retain more of their teeth. Populations at higher socioeconomic levels are able to pay for dental care; however, dental care is often a luxury for vulnerable and high-risk populations. Jonathan Kozol writes, "Bleeding gums, impacted teeth and rotting teeth are routine matters for the children I have interviewed in the South Bronx. Children get used to feeling constant pain. They go to sleep with it. They go to school with it. . . . Children live for months with pain that grown-ups would find unendurable."[8(p20,21)]

Vulnerable Populations

The oral health disparities of the underserved are unacceptable and must be addressed among vulnerable and high-risk populations—children, the elderly, individuals with low incomes, the developmentally disabled, the medically compromised, people who are homebound or homeless, persons with HIV, uninsured and institutionalized individuals, and racial, cultural, and linguistic minorities. For example:

- The rate of untreated dental disease among low-income children aged 2 to 5 years is almost 5 times that of high-income children.[9]
- Among 14-year-old White children, the use of dental sealants, a preventive service, is almost 4 times that among African American children.[5]
- The rate of untreated dental disease among American Indian and Alaska Native children aged 2 to 4 years is 6 times that among White children.[5]
- Oral cancer mortality is 2 times higher for male African Americans than for male Whites.[10]
- People without health insurance have 4 times the rate of unmet dental needs as those with private insurance.[11]

Why should so many Americans, especially children and vulnerable populations, be neglected and experience so much unnecessary pain and suffering when we have the knowledge and resources to prevent it? Oral diseases should not be lifelong conditions that compromise quality of life. Poor oral health affects mortality, general health, nutrition, digestion, speech, social mobility, employability, self-image and esteem, school absences, quality of life, and well-being.[2,5] In addition, recent studies have shown associations between periodontal disease and the incidence of premature, low-birthweight babies[12–14] and between oral infections and heart disease and stroke.[15–17]

Dental care costs should not be a barrier, given other health expenditures. The cost of providing dental care is not driving increases in health care costs. About $60.2 billion will be spent in the United States for oral health services in the year 2000; however, as a percentage of total health expenditures, dental service expenditures have decreased 28%, from 6.4% in 1970 to about 4.6% today.[18]

Prevention

We are fortunate that cost-effective preventive measures for many of these oral diseases and conditions are available. However, they are not being fully used, thus compounding unmet dental needs and disparities. For example, more than 100 million Americans do not live in fluoridated communities[19]; 85% of 14-year-old children have not had dental sealants, a simple preventive measure[5]; and 93% of US adults 40 years and older have not had an oral cancer examination in the past year.[20] For the underserved who are not able to obtain care, the lack of preventive services creates an even greater burden of disease.

Dental Public Health Infrastructure

In addition, our public health system responsible for oral health is in disarray, and its infrastructure is lacking. Eighty percent of local health departments do not have a dental program.[5] Thirty-nine percent of state health departments do not have a full-time dental director, and 8 (40%) of these departments do not have a dental director at all (H. Goodman, State Program Evaluation Committee, Association of State and Territorial Dental Directors, written communication, December 28, 1999). Further, most school-based health centers do not have a dental component,[5] and 44% of community health centers do not have a dental program.[6] Only 136 dentists are board certified in dental public health (S. Lotzkar, American Board of Dental Public Health, written communication, January 21, 2000).

Access

In addition to the lack of preventive services and programs, access to dental care for many individuals and communities is a problem. For example, about 125 million Americans do not have any dental insurance.[5] Furthermore, 81% of nursing home residents have not had a dental visit in the past year,[5] and 80% of children on Medicaid have not had a

preventive dental visit in the same period.[21] Finally, 38% of rural counties have no dentist, and 62% do not have a dental hygienist.[22]

Access to dental care is even more difficult for vulnerable and underserved populations. Access may also be limited by the availability of providers, especially culturally competent providers. However, financial and social constraints affect practice location and the diversity of our oral health workforce, factors that exacerbate oral health disparities among the underserved. The cost of a dental education continues to increase. Approximately 42% of all dental school graduates are more than $100 000 in debt, and about 42% of those who graduate from private dental schools are more than $150 000 in debt.[23] Although African Americans constitute 12% of the general US population, they represent only 2.2% of professionally active dentists.[24] There is also a need for more Hispanic and Native American dentists.

Inequities in access to dental care and preventive services and the lack of a dental public health workforce to respond to these needs have been clearly spelled out in the *Healthy People 2000 Progress Review for Oral Health*[10] and in *Healthy People 2010: Oral Health*.[5] The surgeon general's report on oral health gives us a unique opportunity to sensitize the nation to this neglected epidemic and to stimulate the political will to integrate oral health as part of all health programs and policies.

Recommendations

1. *Oral health must become a much higher priority at the local, state, and national levels, so that oral health disparities can be improved and resolved*. Oral health services should be an integral component of all health programs and all health insurance programs, including Medicare. Government must become more responsive to the oral health needs of the public, especially the underserved. Local, state, and federal health officials, leaders, agencies, and organizations, including organized dentistry, must ensure that health programs and initiatives have a meaningful oral health component and respond to the Healthy People 2010 oral health objectives. More foundations should make oral health a priority. Oral health partnerships, coalitions, constituencies, and legislative action are needed. The public and private sectors, including business, labor, insurers, academia, and the faith communities, must work together.

An effective dental public health infrastructure also needs to be developed and funded at the local, state, and national levels to provide guidance in responding to these needs. Every state and every major local and county health department should have a full-time dental director trained in public health, along with sufficient support.

2. *The federal government must be a role model and set the example that oral health is an integral and important component of all health programs*. The federal government must make oral health a much higher priority in all of its agencies that affect health. It must rebuild its dental public health infrastructure centrally and regionally with leadership and funds to promote cost-effective, population-based prevention programs and improved access to dental services for all, with a special focus on vulnerable populations and the underserved. Creative leadership, incentives, oral health literacy, health promotion, and sufficient resources will be needed from all programs in the federal government to help us eliminate disparities and reach the Healthy People 2010 national oral health objectives.

Although the Oral Health Initiative of the US Department of Health and Human Services is a good beginning, it is limited in scope and impact. The oral health needs of the underserved must be more effectively met by community and migrant health centers, the National Health Service Corps, Head Start, maternal and child health agencies, Healthy Start, the Special Supplemental Nutrition Program for Women, Infants, and Children, area health education centers, school-based health centers, and other such programs. More practical and applied research is also needed to increase the use of, and improve access to, effective prevention programs.

3. *Promotion and use of effective individual and population-based prevention services and programs must become a much higher priority at the local, state, and national levels, especially for children and high-risk populations*. All kindergarten through 12th-grade students should be provided with meaningful oral health education, and children in high-risk communities should have effective school-based dental prevention programs. Federal and state incentives must be provided for such programs. All private insurance programs, dental Medicaid, and the Child Health Insurance Program must include and encourage the use of preventive dental services.

Tobacco settlement funds must also be used to develop and institutionalize effective prevention programs because of the relationship between tobacco use and oral diseases. These services and programs can include school, community, or institutional prevention initiatives that provide fluorides, dental sealants, early childhood caries prevention, and oral and pharyngeal cancer examinations.

4. *The oral health component of Medicaid and the Child Health Insurance Program must be upgraded and improved*. The accountability of state officials involved in dental Medicaid and the Child Health Insurance Program must be increased. Some progress has been made in a few states toward improving dental Medicaid, often as a result of legal challenges. Local, state, and federal agencies, organizations, and constituencies must work together to improve these programs. Adult Medicaid beneficiaries who are at high risk (e.g., pregnant women, the developmentally disabled, and the medically compromised) must be included in dental Medicaid programs, an optional service in many states. An effective statewide distribution of safety-net providers must be available in every state. Disparities in access to dental services for the underserved cannot be corrected until the effectiveness of dental Medicaid programs is improved.

5. *All communities with a central water supply must have fluoridation*. Fluoridation is the most cost-effective preventive measure for better oral health; however, 38% of US communities with public water supplies do not have fluoridation. Other than the recent advances in California, little progress has been made nationally since 1980.

Fluoridation has been called one of the 10 great public health achievements of the 20th century.[25] It should be the foundation for better oral health for all Americans. The US Department of Health and Human Services must play a much stronger leadership role, working with local and state agencies and organizations to promote and support community water fluoridation.

6. *The oral health workforce needs to be modified and augmented*. More dentists, including those of minority backgrounds, should be trained in dental public health. Given the magnitude of debt of recent graduates, this will not occur without changes. Minorities are more likely to receive services in areas where there are racial/ethnic minority providers[26]; thus, minority, inner-city, rural, and low-income students must be recruited, mentored, and funded to attend schools of dentistry, dental hygiene, and public health. This is especially true for African Americans, Hispanics, and Native Americans. In addition to expanding and improving scholarship and loan repayment programs, more creative programs are needed to attract the best and the brightest of these students to careers in population-based dental programs.

State practice acts must also be less restrictive and more responsive to the needs of the public in such areas as national reciprocity for licensees and delegation of duties for dental hygienists and assistants. Other health

professional schools, such as medicine, nursing, and public health, should include oral health in their curriculum so that their graduates can contribute to the resolution of this epidemic.

Conclusions

The oral disease epidemic has been neglected for too long. The richest country in the world, one with a booming economy in the last decade, can do much better. As we begin the new millennium, oral health disparities among the underserved must be addressed. We know how to prevent or control most oral diseases. The surgeon general's report on oral health will grasp the attention of our country. We are once again at the crossroads.[27] Now is the time to integrate oral health into all health policies and programs. We must focus the country's political will to make oral diseases a public health dinosaur of the past. We can and must ensure a legacy of better oral health for all Americans in the future.

Myron Allukian, Jr, DDS, MPH

Requests for reprints should be sent to Myron Allukian, Jr, DDS, MPH, Community Dental Programs, Boston Public Health Commission, 1010 Massachusetts Ave, Boston, MA 02118 (e-mail: myron_allukian@bphc.org).

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The Delta Dental of New Jersey Careers Center Opens at Newark's Central High School

By Kimberly Elmore
May 26, 2009, 9:42AM

The Delta Dental of New Jersey Foundation and the Newark Public Schools celebrated the opening of the Delta Dental of New Jersey Careers Center at Newark's Central High School on May 15th. The opening of the new, state-of-the-art learning environment was made possible through a $75,000 grant from the Delta Dental of New Jersey Foundation.

Delta Dental of New Jersey Foundation(left to right) Dr. Gene Napoliello, President of the Delta Dental of New Jersey Foundation, Central High School student, Water Van Brunt, President - Delta Dental of New Jersey, Robyn Kay, Newark Public Schools, Office of School to Career and College Initiatives

The Delta Dental Careers Center will serve as a hands-on facility for students enrolled in the school's Dental Assisting program. Approximately 26 students will gain the skills to work in the dental field through school-based and work-based experiences. The students will learn about dental science, including how to use dental materials, instruments, and techniques. Additionally, safety, employment skills, professionalism, and applicative law are a major focus of the student's learning. This program has been running for five years.

One of the leading factors to the evolution of dentistry is the increasingly important role of dental assistants. The Delta Dental of New Jersey Foundation recognizes this link and supports dental assisting education programs such as Camden County College, the Bloomfield Health Careers Foundation Dental Assisting Program, UMDNJ School of Allied Health Professionals, and Newark's Central High School, in their commitment to the dental profession.

Students enrolled in the Dental Assisting program are expected to complete the following courses during their four years at Central High School: Dental Assisting I & II as well as Dental Assisting Clinical. Once all three classes are completed, students are eligible to take the National Occupational Technical Institute (NOCTI) exam in Dental Assisting.

Source: NJ.com - http://blog.nj.com/deltadental_impact/2009/05/the_delta_dental_of_new_jersey.html

Resources for Students and Parents

Dental Schools in New Jersey

UMDNJ-New Jersey Dental School
110 Bergen Street, P.O. Box 1709
Newark, NJ 07101
http://dentalschool.umdnj.edu/

Accredited Schools for Dental Hygiene

UMDNJ-School of Health Related Professions
Department of Dental Hygiene
1776 Raritan Road
Scotch Plains, NJ 07090
(908) 889-2410
http://www.shrp.umdnj.edu/

Bergen County Community College
Department of Dental Hygiene
400 Paramus Road, S-337
Paramus, NJ 07652
(201) 447-7937
http://www.bergen.cc.nj.us/

Burlington County College
Department of Dental Hygiene
601 Pemberton Brown Mills Road
Pemberton, NJ 08068
(609) 894-9311
http://www.bcc.edu

Camden County College
Department of Dental Hygiene
Box 200
Little Gloucester Road
Blackwood, NJ 08012
(856) 227-7200
http://www.camdencc.edu

Middlesex County College
Department of Dental Hygiene
2600 Woodbridge Avenue
Edison, NJ 08818
(732) 906-2580
http://www.middlesex.cc.nj.us/

Accredited Schools for Dental Assisting

UMDNJ-School of Health Related Professions
UMDNJ-SHRP
Department of Allied Dental Education
1776 Raritan Road
Scotch Plains, NJ 07076
(908) 889-2411 or (908) 889-2504
http://www.shrp.umdnj.edu/

Atlantic County Vocational Technical School
5080 Atlantic Avenue
Mays Landing, NJ 08330
(609) 625-2249 ext. 1316
http://www.acvts.org

Berdan Institute
201 Willowbrook Blvd 2nd Floor
Wayne, NJ 07470
www.berdaninstitute.com

Camden County College
P.O. Box 200
TAFT Building, Rm. 205
(856) 227-7200 ext. 4471, 4472
http://www.camdencc.edu/

Camden County Technical Schools
343 Berlin Cross Keys Road
Sicklerville, NJ 08081
(856) 767-7000 ext. 5553
http://www.ccts.tec.nj.us/

Cape May County Technical Education Center
188 Crest Haven Road
Cape May Court House, NJ 08210
(609) 465-2161 ext. 432
http://www.capemaytech.com/

Cumberland County Technical Education Center
601 Bridgeton Avenue
Bridgeton, NJ 08302
(856) 451-9000 ext. 346
http://www.cumberlandtec.nj.us/

Institute for Health Education
600 Pavonia Avenue, 1st Floor
Jersey City, NJ 07306
(888) 443-2329
http://www.ihe.edu

Health Science Careers
Find health career programs in your county
http://shrp.umdnj.edu/programs/health_careers/programs/index.htm

Professional Dental Associations

New Jersey Dental Association
The New Jersey Dental Association serves and supports its members and fosters the advancement of quality, ethical oral healthcare for the public
www.njda.org

American Dental Association
America's leading advocate for oral health
ADA
211 East Chicago Ave
Chicago, IL 60611
www.ada.org

American Dental Education Association
The sole organization representing academic dentistry.
ADEA
1400 K Street NW, Suite 1100
Washington, DC 20005
www.adea.org

Student National Dental Association
An integral minority students and minority dental health practioners association that represents members from African-American, Hispanic, and Native American backgrounds enrolled in the 56 US dental schools.
SNDA
www.sndanet.org

The American Dental Hygienist Association
The mission of the American Dental Hygienists' Association is to advance the art and science of dental hygiene by ensuring access to quality oral health care; increasing awareness of the cost-effective benefits of prevention; promoting the highest standards of dental hygiene education, licensure, practice and research; and representing and promoting the interests of dental hygienists.
ADHA

444 North Michigan Avenue, Suite 3400
Chicago, IL 60611
www.adha.org

Student Dental Preparation Programs

Summer Medical and Dental Program
A six-week summer academic enrichment program that offers freshman and sophomore college students intensive and personalized medical and dental school preparation.
www.smdep.org

Gateway to Dentistry (College Students)
A program designed to introduce undergraduate students to a wide range of career options associated with the Dental Profession
Contact Person:
Ms. Maritza Camacho
(973) 972-1645
camachma@umdnj.edu

Decision for Dentistry (High School Students)
A program designed to introduce high school students to career options in the dental profession.
Contact Persons:
Ms. Maritza Camacho-Office of Student Affairs
(973) 972-5064
Ms. Jeannette DeCastro-Office of Student Affairs
(973) 972-7816

Other Resources

Dental Admissions Test
Dental school admissions exam information
DAT
www.ada.org/prof/ed/testing/dat/
DAT Exam Prep
www.scholarware.com

Career Exploration Evaluation Form

We hope you found our resource tool kit helpful in facilitating a visit from an oral health professional. As you know, the purpose of this kit is to encourage students from minority groups that are currently underrepresented in oral health professions to consider a career in the field of dentistry.
Please take a few minutes to fill out this questionnaire so we will know how to better accommodate your school. We greatly appreciate your feedback. Thank you!

1) Was this your first time inviting an oral health professional to your school/organization?
❑ Yes ❑ No

2) How would you rate the usefulness of the tool kit?
❑ Excellent ❑ Good ❑ Satisfactory ❑ Fair ❑ Poor

3) To what grade level of students did you present? _____

4) What was most challenging about setting up your visit? Check all that apply.
❑ Getting the school/organization's cooperation/approval
❑ Finding an oral health professional to visit your school
❑ Finding a time that worked for the oral health professional
❑ Finding a time that worked for the school
❑ Other: _____

5) Which components of the kit did you find most useful? Check all that apply.
❑ Career Descriptions
❑ Bring An Oral Health Professional to your School
❑ Closing the Gap: Oral Health Facts
❑ Resources for students and parents
❑ Sample presentation outlines
❑ Not applicable

6) Is the Career Exploration: Exposing Diverse High School Students to the Oral Health Professions a good resource for you to encourage students to consider a career in dentistry?
❑ Yes ❑ No
Why or why not?

7) What other kinds of programs should the New Jersey Department of Health and Senior Services, Office of Minority and Multicultural Health consider to increase underrepresented minorities in health professions?_____

8) What would you describe as your reason for using the tool kit?_____

Please add any additional comments here, such as suggestions for how we can recruit more.

Please send this form to:
New Jersey Department of Health and Senior Services
Office of Minority and Multicultural Health
Attn: Career Exploration
P.O. Box 360
Trenton, NJ 08625